Just tolerance is not enough:
A guideline for Indonesian mental health professional working with transgender and intersex clients

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As Indonesian citizens, Transgender and Intersex People (TIP) have the same right with other citizens as guaranteed in the Indonesia's 1945 Constitution. However, TIP in Indonesia still live in marginalization and violence. For example, in early 2016, the Minister of Research, Technology, and Higher Education stated that LGBT person should not be enrolled to university since they devastate morality. As the results of the discriminations, the risk of mental health problems might increase among TIP. Surveys in various nations showed that TIP experienced depression and suicide attempts more than general population. They also did self-harm behaviours as maladaptive coping mechanism. Until recently, there is no specific guideline for Indonesian Mental Health Professionals (MHP) to manage TIP as clients. Just being tolerant is not enough. MHP should be able to show their unconditional reception in their services. Through extensive review of recent literatures this guideline is written for Indonesian MHP, particularly psychologists and counsellors, to be more humanizing their TIP clients therefore will result in optimal delivery of care and services. It will discuss about what knowledges and skills that needed by MHP when work with TIP which include assessment and treatment from child to elder stages as well as about family. This guideline is expected to help Indonesian MHP feel more equipped in clinical practice with TIP.

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A. Introduction

As Indonesian citizens, Transgender and Intersex People (TIP) have the same right with other citizens as guaranteed in the Indonesia's 1945 Constitution. However, TIP in Indonesia still live in marginalization and violence. For example, in early 2016, the Minister of Research, Technology, and Higher Education stated that lesbian, gay, bisexual, and transgender (LGBT) person should not be enrolled to university since they devastate morality.[1] As the results of the discriminations, the risk of mental health problems might increase among TIP.[2,3] Until recently, there is no specific guideline for Indonesian Mental Health Professionals (MHP) to manage TIP as clients as well as very limited research about TIP mental health needs.[2,4]Therefore, lack of knowledge of TIP's mental health issues leads to negative attitude towards TIP and tend to ignore their mental health needs.[5,6] Just being tolerant is not enough. MHP should be able to show their unconditional reception in their services.

Through extensive review of recent literatures this guideline is written for Indonesian MHP, particularly psychologists and counsellors, to be more humanizing their TIP clients therefore will result in optimal delivery of care and services.[7] It will discuss about what knowledges and skills that are needed by MHP when working with TIP, which include assessment and treatment from childhood to elderly stages as well as about family. This guideline is expected to help Indonesian MHP feel more equipped in clinical practice with TIP. It is also intended to be flexible in order to meet the diverse health care needs of TIP. However, since references about intersex are not published as much as transgender issues, this guideline was written mostly based on transgender articles that hopefully can be applied to intersex community.

B. TIP and Their Challenges

1. Understanding (Gender Nonconformity and Gender Dysphoria)

Transgender and intersex are part of gender identity and reflection of diverse human sexualities. It is not a pathology and have been known in many cultures across the world.[8-11]In non-Western culture TIP may be more tolerated or accepted.[2,12,13] In some cultures, TIP are even respected as spiritual leaders.[11] But on the other hands, some religious or spiritual traditions discouraged the TIP existence. It makes TIP feel shame and guilt, rejected by religious community and impair their faith.[13]It is difficult to estimate the number of TIP due to broad definitions of it and many TIP keep their identity because of shame and fear of discrimination.[8] Even some of them have to marry because of social pressure or just to protect themselves.[14] Moreover, TIP in rural areas may not always disclose their gender identity due to concerns for safety and privacy.[15]

Confusion remains in international level where people think gender identity is similar with sexual orientation such as homosexual. People categorize TIP as a gender nonconformity (a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex).[11] The conflict between gender identity and cultural norms results in gender dysphoria (GD).GD is a discomfort or distress that is caused by a discrepancy between one's gender identity and that person's sex-assigned at birth (and the associated gender role and/or primary and secondary sex characteristics).[11] However, only some gender-nonconforming people experience gender dysphoria at some point in their lives.

2. Stigma, Discrimination, and Violence

TIP are easier to be recognized compared to LGB people from their gender expression or anatomical sexual characteristic. Media also frequently portray transperson as a joke in drag show and comedy or as a person with mental disorders and negative behaviours.[14,16] It makes TIP around the world experience stigma, discrimination and violence from family, society, and government more often than LGB people.[7,12,14,16-18] But ironically LGB get more attention, social support, and health services compared to TIP.[16]

Transperson in particular stigmatized as sexual predators, sexual workers, or HIV spreaders.[5,14,19] TIP are discriminated in various basic life aspects, including healthcare, housing, education, employment, and law protection.[4,8,19] Even more, TIP are criminalized for accessing facilities such as toilet that do not match with their sex-assigned at birth.[19] Sadly, transphobia (prejudice, discrimination, and gender-related violence due to negative attitudes toward trans identity) is also showed by LGB people who hold a binary sexual and gender identity.[12,20] As the result of stigma and discrimination towards TIP, they often experience violence including physical and psychological abuse.[12,17,18] The harassment and violence sometimes also come from health professionals and police.[16,18]

3. Mental Health

Stigma, discrimination, and violence experienced by TIP affect their mental health and lead to minority stress.[2] Many of TIP feel shame, powerless, have low self-esteem and quality of life, and experience internalized transphobia.[4,17,18,20] In some case, TIP do self-harm such as genital mutilation, auto-castration, substance abuse, or getting involved in high-risk sexual behaviour to cope with their life challenges.[12,13,18] Depression, suicidal ideations and attempts among transperson are also recognized higher than general population, especially who are rejected by their family and experience transphobic treatment from health services.[6,8,16,18] Previous studies showed that 55-62% of transperson had depression, about 64% had suicide ideation, up to 30% had suicide attempts.[4,12,13,18] The trauma from transphobic treatment hinder them to access criminal justice system and health care provider including mental health professionals.[2,12,18] TIP are unwilling to share their trauma with their family because they feel untrusted and afraid to be rejected.[12]

C. Various Types of Client

It is important to understand clients based on their developmental stages, especially childhood, adolescence, and elderly because they have different characteristics compared to adult clients.[3,16] Client in gender identity issue is not only TIP but also their family, including couple and parents. Therefore, it is essential to understand what they need when they come as clients.

1. Child and Adolescent

“Female-affirmed” and “male-affirmed” are better terms used in child and adolescent case that replaces male-to-female (MTF) and female-to-male (FTM) terms. It emphasizes that clients not moving from one gender to another, but into an affirmation of the gender they have always known themselves to be.[10] There is a different proportion of gender identity case based on sex ratio. The male-female ratio for children with GD under age 12 ranges from 6:1 to 3:1. While the ratio among adolescents older than age 12 is close to 1:1.[11] Pre-pubertal children who were referred for assessment of GD will be more likely to identify themselves as homosexual in adulthood. Only 6-23% of boys and 12-27% of girls showed a persistence symptoms of GD when they reach adulthood. However, children may have gender-nonconforming behaviour that persist into adulthood but it is not automatically diagnosed as GD and does not necessarily require treatment.[11] Another research found that about 53% of female-affirmed and 60% of male-affirmed clients knew their gender identity since 4-6 years old.[10] Sometimes clinicians with lack of experience in gender identity cases will misdiagnose GD as delusional problems.[11] MHP need to assess psychological, family, and social issues of children and adolescents client before recommended any physical interventions.

GD symptoms could be seen in children as young as age two when they express a wish to be of the other sex, be unhappy about their physical sex characteristics and functions, as well as prefer clothes, toys, and games that are commonly associated with the other sex, and prefer playing with other-sex-peers. In most children, GD will dissolve before, or early in, puberty. However, in some children these feelings will intensify and body aversion will develop or increase as they become adolescents and their secondary sex characteristic develop. In addition, the density of these features is quite broad from one child to another.[11]

Not all children with gender-nonconforming behaviours will want to experience physical transition. It is more critical for them to experience social transition including change of gender role and possibly gender expression.[10] MHP need to aware that under assessment or clinical setting, children may behave differently compared to when they are with their peers or under parents' observation. It happens because self-consciousness or feeling of being "examined" increase and stimulate them to behave in a manner they feel will please the clinicians.[10]

Previous studies showed many adolescents with GD did not report a history of childhood gender-nonconforming behaviours. Adolescents with GD may experience anxiety and depression, and/or present oppositional defiant disorder. MHP also need to consider high prevalence of autistic spectrum disorders among adolescents with GD.[11] Because of family rejection, many trans-adolescents live as homeless youth.[12] Physical transition or intervention is not necessary for a pre-pubertal adolescents because their hormones have not yet modified they body. But MHP may consider hormonal intervention for clients with age among 12-14 years old because puberty has affected their bodies and mental health.[10,11] Early use of puberty-suppressing hormones, at least 12 years old and under paediatric endocrinological advice, may defer GD effects more effectively than later use.[11]

2. Elder

Transelder is an underserved community in public services and is often rejected.[12] Some of them have trauma and internalized transphobia, particularly related to mental health service visiting, and others hide their gender identity for a long time to avoid transphobic discrimination and because it was a taboo topic.[5,16] Transelder who hide their gender identity feel like living in a prison of their body.[16] Transelder clients who disclose their identity in retirement age are more likely to have more time for self-reflection and willingness to express themselves authentically. At the same time, they also worry to be left by their family or friends and then feel lonely. The lonely feeling is stronger when transelder use the internet and find more people just focus on sex rather than serious relationship. They also worry about their old body appearance and health status. Some transelder experienced unpleasant health services when seeking physical intervention and being told by MHP that transelder should not think about that because they only have short time left to live. Transelder is also afraid if one day they will live in nursing home and the staffs or caregivers will refuse to give them care. As the consequence, some transelder come back to hide their gender identity, move to new place to bury their past, or the worst case is taking their life.[16]

3. Family (Parents and Couple)

Most of parents and partners of TIP who come to MHP usually want to know what happened to their beloved one. Some parents think that their child has mental illness thus becoming homosexual. On the other hand, some parents might have basic knowledge about gender identity but are confused about what action they should take.[10] Family in this situation may need education about gender and sexuality tailored with local culture perspective, intervention that is appropriate for TIP, support group or community availability, and other service provider that is TIP-friendly such as paediatrics and developmental psychologists. MHP should also discuss the implication of disclosure, including the risk of stigma and discrimination, and how to maintain safety and self-esteem of TIP.[10]MHP also need to explore if TIP do violence, physically or psychologically, to their family. TIP could abuse their significant other, especially in relationship.[12,13] A partner of TIP might feel shame or fear to disclose they negative experiences about their beloved one.

Family of TIP could also experience negative emotional feelings such as shock, sadness, disbelief, denial, anger, and betrayal.[13] They also could suffer from guilt because they thought that they did something wrong that affected their beloved one's gender identity. Sometimes parents also feel shame of themselves because they cannot genuinely accept their children.[10] MHP need to emphasize that TIP need their family support as

the buffer of social stigma and discrimination, especially for pre-pubertal transchild.[10,13] Family support is crucial because previous study found that lack of familial support is a predictor of regret after doing SRS.[10]

D. MHP Competenciesand Roles

TIP have difficulty to find friendly and competent MHP to work with them, especially in rural areas. Even sometimes visiting MHP is a traumatic experience for TIP because the long history of pathologization of gender identity diversity in health professions.[4,12]Previous studies[20,21] found general problems appear in gender identity case: 1) many MHP are inexperience in working with ITP clients, 2) MHP have lack of understanding, or even misunderstanding, about gender and sexuality issues, and 3) some MHP show rejection or bias in their practices when working with TIP clients. To answer those problems, some professional organizations such as the American Medical Association (AMA), the American Psychological Association (APA), the National Association of Social Workers (NASW), and the American Medical Student Association (AMSA)had initiated training to promote competency in gender and sexuality issues since early 2000.[12]In addition, MHP roles are not just limited as counsellor or therapist but could also include as educator and advocate that will be explained later in this section.

1. Competency: Knowledge, Attitudes, and Skills

Information about gender and sexuality are extremely rare to be included in mental health educational curriculum that cause lack of knowledge when working with TIP clients.[6,20] Previous studies even found that TIP clients need to educate their MHP about gender and sexuality because of the misunderstanding owned by MHP.[12,20] Therefore it is crucial for MHP to upgrade their knowledge independently about gender and sexuality, sexual health concerns, pathologization (and the depathologization) of gender identity and sexual orientation, and human growth and development.[10-12,20,22] MHP also need to understand the challenges, including stigma-discrimination-violence, faced by TIP as a part of heterosexism culture and its impact towards TIP mental health and life.[22] Sociocultural and local wisdom knowledge related to gender diversity is another essential aspect that MHP need to know in order to understand their clients holistically.[11,17,20,23] MHP should consider that in some cultures, religious and spiritual practices may be important for TIP but at the same time it brings a challenge as a result of the struggles between their faith and gender identity.[22] When reading research reports and literatures, MHP should be aware of the limitation of research methods and generability as well as any potential of gender-bias or heterosexism perspectives upheld by the authors.[22] MHP who live in remote areas and difficult to mobile could join online learning to update their knowledge and expand connections.[16]

Just tolerance is not enough. Studies show that MHP who demonstrate empathy and unconditional acceptance towards TIP tend to be more effective when working with their clients.[17,20] Being sensitive to clients' cultural background is also a key attitude in working with TIP. Non-judgemental attitudes from MHP will encourage TIP to disclose their problems and develop trust in the MHP and therapeutic process.[17,22-24] Clients will feel safe to explore their thoughts and feelings related to gender identity. As the results, clients who feel accepted will have better quality of life and mental health status compared to clients who feel rejected by their MHP.[2] Empathy and unconditional acceptance from MHP are also negatively correlated with premature termination in the therapy.[17]

The primary skill that MHP need to have is ability to reflect and to be aware of their own bias, prejudice, and limiting beliefs or values including sexism, heterosexism, and transnegativity.[17,22-24] The bias and prejudice may influence their professional judgement or performance when MHP work with TIP. Exploring their own bias, prejudice, and limiting belief is challenging because MHP might feel embarrassing and shameful. But it is essential to do because by knowing their own self, MHP could be a genuine individual, feel comfortable when meet TIP, and increase their understanding of challenges faced by their clients as well as find their way

to address those bias, prejudice, and limiting beliefs or values. If in the process they cannot resolve their issues, MHP should decline to work with TIP and refer them to more competent colleague.[11,13,17,24]

2. Roles: Clinician, Educator, and Advocate

The main roles of MHP as a clinician include being a counsellor and a therapist. Clinician might encourage TIP to take the time for gender exploration and build trust in therapeutic process.[25] Meeting with clinician could be an alternative social support for TIP because they might have difficulties to find a safe space to present their true identity. In this process, MHP may help TIP to identify potential challenges of expressing their gender identity, especially if the client wants to do SRS.[11,18] MHP also might give recommendation or referral to other useful resources such as support group community or experienced health professionals.[11,25] MHP who live in rural areas should be aware of socioeconomic and cultural aspects in rural areas that may affect their clients.[15]

MHP could take part as an educator for their clients and society in general. As an educator for clients, MHP may provide information about gender and sexuality, also intervention options (psychological and physical) that are available.[13] MHP may educate their professional colleagues and society in general about gender identity in order reduce the stigma and discrimination towards TIP.[17,26] MHP with transchild or transadolescent clients might educate staff at school so they have basic knowledge about gender identity and willingness to protect the clients from bullying at schools.[11] When delivering their messages to the community, MHP must always be sensitive to the language that they use in order to prevent new stigma arise from the community.[18]

In order to increase the quality of TIP life, MHP may advocate for better services or system to their clients.[6,17] Some areas that MHP could advocate are improvement of healthcare access and quality for TIP,[23,25] development of school anti-bullying policies that include protection of gender identity and expressions,[10,23] and in macro level is advocating the rights and protection of TIP in justice system.[18]

E. Therapy process

1. Paradigm

Why TIP are looking for mental health services? Most MHP will assume that the reason is because of their gender identity conflict. In fact, previous studies[17,18,20,26,27] found that TIP seek help from MHP because of 1) quality of life issues, 2) relationship, 3) stigma and discrimination, 4) mental health issues such as anxiety and depression, and 5) help with gender transition such as support before or after medical intervention. It was found that chronic discrimination may lead to minority stress or depression.[17,26]

When working with TIP as clients, MHP need to apply affirmative and harm-reduction approaches in their professional practices. Affirmative approach is developed from unconditional positive regards and empathy as promoted by Rogers.[17] Clients have the right to express their gender identity and self-definition without prejudice from the MHP.[16,17,20,24,25] It was found that therapy with focus on pathology has failed to address the impact of stigma and discrimination experienced by TIP. In addition, the effect of stigma and discrimination on mental health of TIP is under researched and acknowledged.[20] Therefore, the focus of the therapy is not on the gender identity but more on the uniqueness of client's experiences, their resilience and strengths, and assumption that TIP have resilience and coping resources for positive change or healthy decisions to improve their life.[5,11,17,23]

Within affirmative approach, the primary focus in clinical practice has shifted from diagnosis or pathologization into more inclusive quality of life issues or depathologization.[12,17,20] "Abnormal" label is detached from TIP thus stigma and discrimination experienced by them could be reduced.[20,28] MHP should

proactively encourage themselves to respect their clients' unique experiences and develop their skills to provide inclusive and affirming services.[20] Based on the premise of client's capability to make decision to improve their quality life, MHP should let their clients know what is appropriate to expect within the context of therapy and what is not.[18]

Unfortunately, many TIP do not have insurance to access MHP and they report difficulty to find MHP with affirmative approach. Instead, they are even rejected because of their gender identity.[6,12,20] Moreover, there are still MHP who perform conversion therapy that is aimed to change TIP's gender identity to become more congruent with sex-assigned at birth and leads scepticism among TIPs.[20] Since affirmation approaches respect clients' gender identity and is not pathologized nor classified as disorder, consequently treatment such as conversion therapy is no longer considered ethical.[11] Previous studies also found that conversion therapy has been put into trial in the past but showed no significant results, particularly in the long-term. MHP need to notice that conversion therapy is used in religious group that also reflects misunderstanding of gender identity and sexual orientation.[12]

2. Initial meetings

The first three initial meetings should be used to build therapeutic rapport and perform psychological assessment.[12,13,20,25,26] Using affirmative approach, MHP should ask the client's preferred name and pronouns, discuss their expectations, inquire some potential areas such as medical history, economic and social condition, and family. When asking about relationship status, MHP should ask it as partnership rather than marital status. Sensitive topics that need to be asked carefully are misuse of drugs or alcohol and sexual behaviours. MHP must respect clients who do not want to respond, especially if the questions are about gender transition and violence that they might have.[16,18]

At the end of initial meetings MHP need to write their temporary assessment results and include diagnosis when needed. Some diagnosis that might occur are body image disorders, eating disorders, depression and suicidal ideation, and PTSD.[12,13,18] MHP should be cautious when diagnosing TIP because it has two sides. Diagnosis can help MHP to formulate client's problems and communicate it with other health professionals. On the other hand, the diagnosis could be used to stigmatize and pathologize TIP.[13,20] In addition, MHP need to aware that mental health issues among TIP could be caused by social role pressure, and in turn the mental health issues could affect their role in society.[26] Previous studies found that TIP are at the risk of late diagnosis treatment, especially if they are in transition or physical transition process. They are afraid to disclose their mental health symptoms because they thought it will delay and cancel their hormone therapy or SRS.[13]

3. Intervention

The most known intervention for TIP is physical treatment such as SRS and hormones therapy. Mental health intervention is very rare to be discussed, developed or provided, particularly in rural areas.[15,17,20] However, MHP who work with TIP still need to apply high ethical standard and interventions supported by scientific evidence-base.[18] The main goal of the intervention is to address the problems that TIP have and build their resilience. If clients have drugs and alcohol misuse, additional goal might be ranged from reduction of the misuse to total cessation.[13] If clients have multiple mental health issues, it is suggested to address the issues that most negatively impact their well-being and/or ability to engage in treatment. Previous studies found that these methods work effectively when used with TIP: group therapy, narrative therapy, dream work methods, dance therapy, and phone counselling. However, each methods should be used based on the client's problem and stage of gender identity development.[13,17] MHP also need to intervene the impact of any abuse that clients might have by using interventions that aim to improve clients' self-esteem and trust in others. No-harm agreements, verbal or written, may be used as the first emergency intervention when MHP meet TIP with high risk for self-injurious behaviour.[13]

Physical intervention is not MHP competency but it is important to know because many THP need it but some do not need it at all.[11] For transadolescents, refusing timely medical interventions for adolescents might prolong GD and lead to abuse and stigmatization.[11] For adult clients who undergo SRS, there are some risks to feel doubt, dissatisfaction, or regret related to post-operative pain, surgical complications, changes to sexual function, or disappointment if the result is below their expectation.[13] However, the dissatisfaction rate is quite low which is 1-5% among transfemale and less than 1% among transmale.[11] The regrets mostly come from misdiagnose, failure to complete pre-surgery procedure, and unrealistic expectation from clients.[13]

4. Environment

Besides the initial meetings and intervention process, MHP also need to pay attention to the environment of their clinic.[5,12,16,22] A friendly clinic for TIP should show visual indicators and other signs that represent affirmative approach. The facilities provided, such as toilet, need to be gender neutral. Administrative procedure, such as form or paperwork, should be able to facilitate clients' preference of their gender identity. Clinic staffs should also receive training about gender identity issues so they can respect TIP, for example by asking clients' preference of their nickname or title.

F. Therapy Setting

Family might be involved in therapeutic process with TIP clients when clinically appropriate.[9,13] They could be act as supportive family but some others may feel shame with their TIP family member.[5,13] MHP could assess the family structure for dysfunctionality.[10] In case of family dysfunctionality exists, MHP might want to talk with child's relatives. If parents insist to reject their child's gender identity, MHP might need to explain to them about the risk that will be faced by their child.[11] On other side, functional family or parents will try to observe and listen their child, then gradually understand about their child gender identity and put their child's well-being on the first place. MHP also could ask parents to meet other families who have transchild in order to build social support group. However, consent and confidentially must be the priority.[10]

MHP could try group psychotherapy since previous studies found that this method is cost-effective, able to create safe environment, provide social support, and mitigate the impact of discrimination on TIP.[3,6,11,21] TIP also might broaden their concept of family and look to other TIP community for social support, especially in rural areas.[13,16,24] However, like in any other group, TIP community has their own complex social dynamics that might bring disappointment.[22]

G. Conclusion

MHP need to work collaboratively because there are limited resources available about gender identity and mental health treatment using affirmative approach, especially in Indonesia.[19,20] The collaboration could be in collaborative treatment, research, or just consultation.[23] Some health professionals that could be needed in collaborative work are physician, paediatric endocrinologist, and lawyer who transgender and intersex friendly.[10,11] MHP in Indonesia might read already exist references about mental health of TIP such as American Counselling Association Competencies for Counselling with Transgender Clients[22] and Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People.[11]

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Never give up on being yourself no matter how hard it seems to be. Being you is always worth it - Arin

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